STATE OF MICHIGAN
REPORT OF CLAIM

Please return to:
CITIZENS MANAGEMENT, INC.
P.O. BOX 740
Howell, Michigan 48844-0740
Phone 800-324-9901 Fax 517-540-3100

Is This a Workers' Compensation Claim? Yes ☐ No ☐

Reported By: ☐ Employee ☐ Employer Name: _____

Claimant Information

Employee Name: Last: First: Middle:
Address: Street #: Street: Apt. No / RR No:
City: State: Zip:
Home Telephone #: ( ) Employee I.D. #:

Date of Birth: / / Age: Sex: Tax Filing Status (check one): ☐ S ☐ MS ☐ SH ☐ MJ

Highest level of education completed:

Does your spouse receive any type of Employment Wages, Social Security, Pension, Unemployment, wage continuance, or reimbursement by a Self-insured plan? ☐ Yes ☐ No If so, who pays it?: How much per month?: $

Dependents: (First, Middle Initial, Last names)	Date of Birth	Relationship To employee	Address	$ amount paid for dependent status
	/ /	**SPOUSE**		$
	/ /			$
	/ /			$
	/ /			$
	/ /			$

(Use additional sheet if necessary)

Incident Information

Date of Injury/illness: / / Time of Injury/illness: Date of Knowledge: / / Reported To:

Employer Report Date: / / Reported By: Reported by Title:

Reported by Phone: ( ) Doctor Report Date: / / Last Day Worked: / /

Department Occupation Title:

Supervisor's Name: Supervisor Phone: ( )

Hire Date: / / Shift Worked:

Accident City: State: Zip: Accident County: On Employer Premises?: ☐ Yes / ☐ No

How did the Injury/illness occur?

Injured Body Parts: (1) (2) (3)

If auto accident advise name, address and phone number of your auto insurance carrier/agent.

Phone: ( ) Policy #

In consideration of the payment to me of disability benefits in advance of my having complied with all requirements concerning proof of other income (including amounts of other income) and understanding that such payment may later be determined to be in excess of benefits which should have been paid under a State of Michigan Disability Benefit Program (the Program), I hereby assign, transfer and agree to reimburse the State of Michigan or its Third Party Administrator to the extent of any such benefits paid under the Program for which I am ineligible by reason of benefits being paid to me or on my behalf (1) under any pension plan or retirement program to which the State of Michigan contributed, (2) through or under any Social Security law, Long Term Disability Plan or Worker's Compensation law, or (3) from any other sources which by the terms of the Program are to be taken into account in determining the amount of the disability benefits.

_____ _____
Employee Signature Date

If paying support through Friend of Court: Which County? How Much Weekly? $

Current Department: Agency: Supervisor:

Address: Street #: Street: City: State: Zip:

First day of Weekly wage: / / Hourly rate: $ Hours per week: Days per week:

Incident Information

Name of witness to injury?

Have you had any previous injuries/illnesses? ☐ Yes / ☐ No If so, when, where and what?

Did you receive compensation for these injuries/illnesses? ☐ Yes ☐ No If so, from who and how much?

Medical Information

List names, addresses and phone numbers of doctors that you have been treated by during the last three years:

Name	Address	Phone number	Dates Attended	Is this doctor treating you for current injury/illness?
nnnnn				☐ Yes ☐ No
				☐ Yes ☐ No

Use additional sheet if necessary

Have you been hospitalized for this injury/illness? ☐ Yes ☐ No Where? How long?

Diagnosis from your doctor? _ Did you take time from work? ☐ Yes ☐ No

If yes, how long? From: / / to : / / What is your actual/anticipated return to work date? / /

Date of next doctor's appointment? / /

Other Employment

Were you working a second job or were you self employed when you were injured or became ill? ☐ Yes ☐ No

Name of second employer/business: Phone No: ( )

Address:
If yes, are you are losing time from or receiving income from that employer, what was your last day worked and what were your weekly earnings?

Other Income

Do you receive any type of Social Security, Pension, Unemployment, wage continuance no-fault benefit, or reimbursement by a Self-insured plan?

☐ Yes ☐ No If so, who pays you?

Total amount of other income per month.

Warning: Any intentional false statement in this claim or willful misrepresentation relative hereto is a crime punishable by a fine and/or imprisonment (Sec. 2088 Michigan Insurance Code)

All income you earn while receiving benefits must be reported. I certify I have read the information on this sheet and have answered the questions correctly to the best of my knowledge

Signed Date

Printed Name